RESPONDING TO TRAUMA OR CRISIS

A Working Document on a coordinated and managed approach to trauma while operating as a decentralized movement.

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DEALING WITH TRAUMA AND CRISIS.

1 Peter 5:2

"So I exhort the elders among you, as a fellow elder and a witness of the sufferings of Christ, as well as a partaker in the glory that is going to be revealed: *2 shepherd the flock of God that is among you, exercising oversight, [a] not under compulsion, but willingly, as God would have you; [b] not for shameful gain, but eagerly; 3 not domineering over those in your charge, but being examples to the flock.* 4 And when the chief Shepherd appears, you will receive the unfading crown of glory.

We are exhorted as elders but not only as elders to respond to the suffering of another of those that are under our care. Furthermore, we are encouraged to respond from love and compassion, this motivation needs to be above the sense of duty.

Our response should be genuine and empathetic over and above the sense of duty.

Warmth, Empathy and Respect are key to managing any trauma or crisis situation.

- Warmth – Being caring, attentive, accepting, and genuinely interested in another's felt disposition without been possessive or controlling.
- Empathy – the ability to "feel with" the distressed and to see the world as he or she sees it, without owning personally those emotions or feelings felt. Without an empathetic understanding of the helpee's world and their difficulties as they see them, there is no basis for helping.
- Respect – Valuing and appreciating the other while increasing measures of self-worth.

What is Trauma?

Trauma refers to an experience that is emotionally painful, distressing, or shocking, which can result in lasting mental and physical effects. Emotional harm resulting from a traumatic incident is essentially a normal response to an extreme event. There is not a specific time period during which a person will react to a traumatic incident; reactions may appear immediately after the event or days, weeks, or even years later.

Types of Traumatic Situations:

- Assault / Robbery
- Serious Team illness on the field
- Death of a staff member/student/family member etc.
- Severe accident/Medical Emergency
- Motor vehicle accidents
- Suicide or suicide attempt
- Acts of Terrorism
- Hostage/Kidnapping or Hijacking
- Civil Unrest in a nation
- Sexual Assault/Rape
- Spiritual Abuse
- Child Abuse/Child Abuse Accusations
- Accusations of been involved in a crime
- Arrest/Imprisonment
- Negative Media attention towards your YWAM location
- Political unrest (riots, armed conflicts, terrorism etc.)
- Natural disaster
- Murder
- Mental Health Deterioration
- Pandemics

Understanding some Psychological and Physical Effects of Trauma

Following a traumatic event, or repeated trauma, people react in different ways, experiencing a wide range of physical and emotional reactions. There is no "right" or "wrong" way to think, feel, or respond to trauma, so don't judge your own reactions or those of other people. Your responses are NORMAL reactions to ABNORMAL events. Our feelings are neither wrong nor right but they are real.

NB: One of the important psychological reactions that happen to people in trauma or a crisis are the following question: "Who is managing or coordinating this situation?" "Who do we go to?" "Who will be taking care of myself and others?"

“Who is in charge?” “Who is the decision maker?” Failing to answer these questions can and will introduce secondary degree trauma.

Emotional and psychological symptoms of trauma:

- Shock, denial, or disbelief
- Anger, irritability, mood swings
- Guilt, Survivor Guilt, Shame, Self-Blame
- Feeling Violated
- Vulnerability
- Feeling sad or hopeless
- Confusion, difficulty concentrating
- Anxiety, Fear, Insecurity
- Withdrawing from others and Isolation
- Feeling disconnected or numb
- Depression.

Physical symptoms of trauma:

- Insomnia or nightmares
- Being startled easily
- Racing heartbeat
- Aches and pains
- Fatigue
- Difficulty concentrating
- Edginess and agitation
- Muscle tension
- Other impairment of cognitive abilities
- Heightened Sense of Awareness

The following factors contribute to how emotional response to trauma varies:

Intensity of Traumatic Event

- Duration of incident
- Perception of danger
- Level of exposure

Understanding the Person Affected

- Coping skills
- Social characteristics
- Previous experience
- Religious and theological worldviews

RESPONDING TO THE TRAUMA

It is essential that a senior leader(s)/elder(s)/ team leader(s) reach out to those affected.

Local Incident:	→	Requires a local elder response.
Regional or Multi-Regional Incident:	→	Requires 2 of the following: a local, regional or continental elder response.
Global Incident (aka multiple nationalities involved in a traumatic event):	→	Requires all (local, regional, continental and global elder responses to varying degrees).

The Importance of Senior Leaders/ Elders/ Team Leaders Responding to the Trauma

We believe that there is great value in the response of eldership in times of trauma. Their presence is received as a deeper level of care by those involved).

- Helps to mitigate (to alleviate, reduce, diminish, lessen, lighten) the trauma;
- Values and affirms the individual and their experiences;
- Helps to reduce secondary trauma (making the situation worse by mishandling or neglecting to respond to the situation well);
- Helps assure people that, despite the messiness of the current situation, there is hope;
- Helps to bring direction;
- Substantially increases mission field resiliency;
- Increases a sense of safety and diminishes vulnerability. People feel vulnerable when a traumatic situation is not addressed, it can affect whether people will stay in the mission and how effectively they will function from then on;
- A leader's involvement helps normalise the situation and can aid emotional stability and understanding.

GENERAL THOUGHTS

Golden rules of crisis response:

PRE-CRISIS / PREVENTION

1. Be prepared and informed
2. Build a support network at your location (even outside of YWAM)
3. Create awareness in your team

DURING THE CRISIS

4. Remain calm, focused and take responsibility
5. Ensure everyone's safety
6. Form a crisis response team and cooperate with it
7. Communicate quickly, clearly and with wisdom

AFTER THE CRISIS

8. Be aware of the possibility of trauma
9. Evaluate

GOLDEN RULES OF CRISIS RESPONSE

Pre-Crisis / Prevention

1.) Be prepared and informed:

- Please ensure that you have an information data sheet of ALL staff on your team (short and long term) completed. **Please see data sheet template attached.** Keep a **hard copy** of this document at a place in your YWAM location that is both accessible, and provides the needed confidentiality (with clearly defined and restricted access for this sensitive information). Having this document available also in digital format makes it more accessible in case of a crisis;
- Identify the potential risks in your location (car accident, theft, riots, assault etc.);
- Take the needed precautions;
- Stay informed about your location through TV, embassy updates, neighbourhood gossip etc.

2.) Build a support network at your location with:

- Locals who know the language/culture and the legal procedures e.g. reporting an accident to the police, funeral requirements;
- People who could deal with the Media;
- Local pastors, Missionaries from other agencies;
- A local lawyer who could be consulted if need be;
- Psychologist, Pastors, Debriefers who could help with the aftermath of a crisis.

3.) Create awareness in your team

- Discuss potential crisis' and responses in your staff meetings. Allow for questions and don't rush through this time. Be clear in your communication, repeating yourself if need be;
- Discuss in your leadership team who the point person will be in the base leader's absence;
- Communicate who the Media Liaison person would be and how they can be reached in case of the media calling the location, base or staff member. Individual Staff Members should not volunteer any information without consent from the Media Liaison;
- Information should not be shared on social media until all relevant people such as YWAM Leaders, Family, Church, Governmental authorities have all been informed.

During The Crisis

4.) Remain calm, focused and take responsibility

- As local Elder or Leader you need to give full attention to the crisis;
- Ensure that relevant information continues to flow as the crisis unfolds.

5.) Ensure everyone's safety

- Ensure everybody goes to/stays at a safe location;
- Provide the following if needed: first aid, emotional and spiritual support;
- Call for appropriate help e.g. Ambulance, Fire Brigade, Police etc.

6.) Form a crisis response team and cooperate with it

- Inform your National/Area Circle Leadership Teams and/or Membercare Circle and decide together what kind of response team is needed and what their roles might be (Manager, Communicator, Critical incident debriefer etc.) Be clear on what you might expect of them in the crisis;
- Agree on a clear communication line and how this team will respond. At the end of each point of contact (e.g. skype, phone, SMS, in person etc.) agree when the next communication will occur;
- Involve people from your local support network (Pastors, Psychologists, Community Elders and Leaders etc.)

7.) Communicate quickly, clearly and with wisdom

- Who needs to be informed? (Global/National Leadership Circle Teams, family, sending church or YWAM base, local authorities etc.);
- Who is responsible for what kind of communication (e.g. Global/National Leadership contacts family in case of death of a YWAMer). Please clarify with the crisis response team;
- Keep a detailed log of all communication and actions taken, which include content of the communication, date and time of communication, name and telephone number of person contacted;
- Appoint a Media spokesperson (base, national or other senior leader). Prepare a media statement in the interim (see attached Preparing Media Statement);
- Ensure confidentiality (NO Facebook posts, timing of communication to broader group etc.)

After The Crisis

8.) Be aware of the possibility of trauma

- A crisis involving danger, injury or death is usually traumatic;
- A Critical Incident Stress Debriefing (12-72 hours after the event) helps greatly with the emotional recovery of those involved:
    i) This is recommended to be done by a trained person. Make contact with a Pastor, Psychologist, Debriefer or Membercare Circle to assist in this process. If this is not available try to find somebody trusted within your midst who can facilitate a reasonable debriefing process, they should fit a debriefer's profile and be able to make use of the Debriefing Module (see page).

9.) Evaluate

- What went well and where do we need to improve?
- Identify who might need some further personal follow up.
- Do you need external help to evaluate?
- Prepare report within 72 hours after traumatic event detailing the following: written report documenting the event; time; those involved and response. This satisfies a legal requirement that is held by many nations.

GOOD PRACTICE FOR HELPING TRAUMATIZED PEOPLE

1. Empowering the traumatized

Traumatized people feel powerless, without any control, everything has been taken out of their hands. Giving them control over something, however small, is a powerful element in the recovering process. Giving them choices wherever possible – is crucial!

a. Be there, offer your presence and help but do not take over. Let them be involved in some (small) tasks, let them help with practical things or whatever they like.
b. Ask them what would help them: being alone or being together with others; writing or letting others write for them and they proofread it, etc.
c. Who would you like to be with you? Who should be informed about your situation?
d. Who would you like to speak to on the phone? Who should just be informed by another person? Who would you like to answer the phone when it rings?
e. Emphasize their resilience and how well they have done in coming through this so far! Tap into their strengths!

2. The best thing you can do for a traumatized person is to be a friend!

Be sensitive and real, observant, but not patronizing. In a well-meaning unconscious way, we sometimes treat the survivor as a 'victim' and take over or we see them as a 'psychological case'.

a. Listen
b. Ask, "What would help you?"
c. Check gently whether your friend eats, rests, sleeps.
d. "You will need all your energy for the next stretch of the journey. I could keep watch over the phone while you relax and sleep".

3. Watchful waiting

a. Make sure people feel safe, and are around people they trust.
b. Continue to check what their needs are. Give them choice!
c. Normalize and educate: "What you experience, is normal; no need to get upset with yourself and with your reactions! In a couple of weeks, the symptoms will fade/subside. If not, and you are still stressed, then there are specialized people we know and whom you could meet. Meanwhile, let us look at what could reduce the pressure and we can discuss ways from which you can choose what suits you best"
d. Don't say, "You will experience this and this!" Rather, "if you experience some of these symptoms that is not surprising, actually, this is a normal reaction to an abnormal event! Living with such uncertainty is so hard! And you have done so well!"
e. "High risk" people and those who ask for professional help should be referred to a professional.
f. If after three weeks there is no easing of the symptoms, facilitate that the person can see a professional. Contact professionals early on for quick deployment if needed.

4. Recognizing one's limits and deciding to leave

a. Recognizing and accepting one's limit is a strength and not a weakness!
b. It is good protocol to have a rota system for people in responsibility to be released from a task after a certain time. This length of time may vary since we are all different in our physical and emotional make-up.
c. Handing over responsibility is not a failure but good stewardship and being true to what the inner voice tells us to do.
d. If we observe that people's well-being changes, try to give them choice rather than ordering them what to do. Ask gently, "What would help you?" Create an atmosphere of acceptance in weakness and where the person can still carry some kind of responsibility, albeit reduced. It could make people feel worse if they were just put aside, without any responsibility, especially when before the crisis they were in a position of responsibility.
e. Options when to leave and where to go (intermediate place of shelter?) should be discussed with each one. Give ownership in the practical arrangement but be there if your help is appreciated/needed.

5. Togetherness of those who suffered together

a. Staying together with those who went through the same crisis experience can be a healing element. There is special understanding and bonding in the group. People back home, however much they love and care for us, at first seem as strangers.
b. If people want to leave that is fine. Make sure you help them to know what they are going into. Help those at the other end how to receive them.
c. Sometime after the incident – not too much later – it is good practice for the group to come together again for "closure". Think about who should be there: workers who were on furlough? At least one

professional – in a friendly mixing manner, not in an attitude of professionalism – should be around for those who would like to talk. There is no need for everyone to be "treated" by professionals.

6. Returning to the passport country

a. People may want to attend funerals which is very helpful as a farewell and closure.
b. Have some kind a ritual of thanksgiving if attendance at the funeral is not possible.
c. In the event that the crisis requires a trip home, consider whether the person may need if someone to accompany them.
d. Get information, be aware, have a plan: media might be present at the airport! Ask for protection from journalists; perhaps have a prepared script ready and stick to it!
e. What is your home situation? What are you looking forward to? What might be difficult?
f. Discuss the feeling of loss and being displaced. Loss of responsible position, being in high demand and loss of purposeful living.
g. What would help you? Have someone stay with you? Who should that be?
h. Who could be a contact person for you so that you will not be 'overwhelmed by love'? In consultation with you that person could 'organize' (1) who could help you with what and (2) how many people come for how long.
i. Who could answer the phone and shield you from the media?
j. "You can decide how long you want this kind of help and what kind of steps into everyday life you want to take!"
k. People back home should learn about common reactions to crisis. They should be aware that each person is unique in the way they react to and process a crisis. They must not judge the survivor. They should be knowledgeable about the 'grief process'.

7. People who are indirectly affected by the crisis

a. Who else might be affected? Colleagues in the company whether near or far, supporters, churches, classmates, those who have experienced a trauma before, etc.
b. Information helps them to feel included. They should have a contact point for asking questions.
c. Finding a means of expressing thanksgiving and sorrow to those directly affected, perhaps giving them a gift.

d. Those indirectly affected need to be assured that the mission cares. They need to know what is being done in terms of care for the traumatized. Inform them about the reliable sources from which the leaders take advice. They need to know that not sending in an 'army' of professionals during the first few weeks is not lack of care but exactly according to latest research. They should be assured that 'high risk' people and people who desire to speak to a professional will be facilitated to do so.

PROCEDURES IN CASE OF DEATH OF YWAM WORKER

Incidents involving death vary, therefore standard emergency plans will need adaptation, but the following are some guidelines.

Legal aspects

- Inform the Police in case of accident, crime related etc.
- Inform deceased's embassy. Police can assist in this case;
- Obtain Death Certificate from the appropriate authority e.g. Doctor, Forensics Unit etc.
- You might need to be in contact with necessary forensic authorities for the removal of the body. Police or medical personnel could assist;
- Be careful to observe the norms and procedures of the country you are in.

Communication

- AS SOON AS POSSIBLE inform the Base Leader, Area Circle Eldership/Leadership, or your immediate senior leader;
- The National Leader should make the following initial contacts: May also consult with Area Circle Leader)
    - With the immediate family on the field and in the home nation of the deceased person by a personal visit to the family if possible. If this is not possible then it is strongly recommended that help is sought from the family Pastor, next of kin, deceased's Pastor, another YWAM Base Leader. In some cases, the Police Chaplin may also be called upon.
    - In the event of a critical injury consult with Membercare Circle, Base Leader, Area Circle Elder to make contact with the family directly.
- After initial contact with the family, try to assure that accompanying family members of the deceased be facilitated in making phone calls to their family members and other immediate relations as soon as possible;
- Keep information off social media until all family members and other immediate relatives have been informed.

Burial and Funeral

- Enlist the help of a listed undertaker to arrange for the storing of the body. Some state/governmental mortuaries charge very high fees if the body is not removed after a few days;
- The undertaker may also assist with the repatriation of the body and all other legally required processes, such as body embalming, transportation requirements and/or cremation. Someone with the authority to sign legal documents on the base should assist in doing so;
- Burial requirements (some countries require burial within 24 hours; others require embalming before return of body etc. These issues need to be thoroughly checked);
- Inquiries should be made of the funeral director regarding service costs involved;
- The local YWAM leadership should play an active and supportive role to the family members as the process unfolds.

Family needs upon visitation

Below are some of the things that they might want to do:

- Visit the accident site. It is advised that you link them with an appropriate leader on the base and if possible the authorities assigned to the case. They should have an opportunity to ask all the questions that they have;
- Visit the Hospital. The family may want to visit the hospital where their loved one was cared for and possibly to meet the Doctor involved;
- The family may want to meet with the friends of the deceased;
- The family may want to connect with those that the deceased had ministered to;
- See where she or he stayed and lived;
- Sorting belongings. Sensitivity is required as some families or community culture prefer to do this themselves and not another stranger;
- Funeral/Memorial Service: Some families may request this. This should then be facilitated and where possible friends of the deceased may wish to assist in the service. In facilitating this be sensitive to the family's needs and have them met wherever possible.

Family members on the field

If there are survivors on the field who will be returning to their home country:

- Local YWAM staff should arrange for a memorial service at the place of work if possible;
- Local YWAM leadership should make arrangements for YWAM representation at the memorial service in the home country;
- If family members of the deceased person terminate their service with YWAM and return to their home country, decide early whether or not someone from YWAM should go with them (if in doubt, accompany them).

Staff or Student Needs

- Viewing of the body: Care should be taken to give counsel and wisdom, should this be an option. Some may want to view the body but have little understanding of what this could do to them emotionally (it could further traumatise them). Try to not let them go alone.
- Sorting through deceased items: Parents may ask a friend of the deceased to help in this task. Be aware that, because of cultural differences, this might be a very difficult experience. Advise the family and the friend and provide an option for the staff or student to be relieved of this responsibility if needed.

GRIEF AND LOSS

"An expression of love."

Before we start on this often painful matter I would like to mention that we are aware that different nations and cultures grieve differently in a time of loss, should there be something that you have found in your culture regarding the grieving process that you find particularly helpful to the process please E Mail us at info@ywamafricare.org.za so that we may possibly further research it and add it to the document as these documents will continue to remain in the making. With thanks. Dave Peter.

Grief.

Losing someone or something you love is very painful. After a significant loss, you may experience all kinds of difficult and surprising emotions, such as shock, anger, and guilt. Sometimes it may feel like the sadness will never let up. While these feelings can be frightening and overwhelming, they are normal reactions to loss. Accepting them as part of the grieving process and allowing yourself to feel what you feel is necessary for the integration of the loss into our lives.

When someone close to us dies, not only do we lose that person on the physical level. We also face the loss of potential—what could have been. So our pain can involve missing that person's presence: sleeping in a bed that's half empty, craving the scent of their hair or longing for their embrace or just to hear his or her voice. More than that, we are almost constantly reminded of their absence, especially at certain life markers. If a spouse dies, we might wonder what life would have been like had that person survived. Would we have brought children into the world? How would we have celebrated our anniversary? When a child dies, at whatever age, we might imagine what kind of car they would have wanted or what grades they would have gotten at school.

There is no right or wrong way to grieve — but there are healthy ways to cope with the pain. You can get through it! Grief that is expressed and experienced has a potential for healing that eventually can strengthen and enrich life.

What is Grief.

Grief is a natural response to loss attributed to a spiritual and emotional suffering that we can feel when someone or something is taken away. The word itself was originally derived from the Old French word "grève," meaning a heavy burden. In English "grief" generally means an experience of deep sorrow, one that touches every aspect of our lives both spiritually, emotionally and in some cases physical toll on our lives. Grief can literally "weigh down" the person who must face the reality of a gut-wrenching loss. The more significant the loss the more intense the grief. Grief may be extremely painful but can be overcome if faced and experienced.

Grieving is a personal and highly individual experience. The grieving process takes time. Integration of our loss happens gradually; it can't be forced or hurried – and there is no "normal" timetable for grieving. Some people start to feel better in weeks or months. For others, the grieving process is measured in years. Whatever your grieving experience, it's important to be patient with yourself and allow the process to naturally unfold.

Factor's influencing how we respond to a particular loss.

- The nature of the loss (what was our relationship like with that person? how did he or she die?)
- Our world view to suffering.
- Our world view on God.
- Personality and coping style.
- Our individual personalities and coping styles.
- Our experiences, including what we have learned about loss from others throughout our lives.
- The support we have in helping us cope with our loss.

Stages of Grief.

"They are not meant to tuck messy emotions into neat packages. They are responses to loss that many people have, but there is not a typical response to loss, as there is no typical loss. Our grieving is as individual as our lives."

- *Shock and Denial* - "this can't be happening to me", looking for the former spouse in familiar places, or if it is death, setting the table for the person or acting as if they are still living there. Keeping the house just as it is, not packing up the cupboards. A struggle to accept or even acknowledge the loss.

- *Anger* - "why me?", feelings of wanting to fight back or get even with spouse of divorce, for death, anger at the deceased, blaming them for leaving, anger at medical staff, or one's own self or God.

- *Bargaining* - often takes place before the loss. Attempting to make deals with the spouse who is leaving, or attempting to make deals with God to stop or change the loss. Begging, wishing, praying for them to come back.

- *Depression* - overwhelming feelings of hopelessness, frustration, bitterness, self-pity, mourning the loss of person as well as the hopes, dreams and plans for the future. Feeling a lack of control, feeling numb. Perhaps even feeling suicidal.

- *Acceptance* - there is a difference between resignation and acceptance. You have to accept the loss, not just try to bear it quietly. Realization that it takes two to make or break a marriage. Realization that the person is gone (in death) that it is not their fault, they didn't leave you on purpose. (even in cases of suicide, often the deceased person, was not in their right frame of mind.) Finding the good that can come out of the pain of loss, finding comfort and healing. Our goals turn toward personal growth. Stay with fond memories of person.

Contrary to popular belief, you do not have to go through each stage in order to heal. In fact, some people resolve their grief without going through any of these stages. And if you do go through these stages of grief, you probably won't experience them in a neat, sequential order, so don't worry about what you "should" be feeling or which stage you're supposed to be in.

Kübler-Ross five stages

Grief is a roller coaster not a series of stages.
It is best not to think of grief as a series of stages. Rather, we might think of the grieving process as a roller coaster, full of ups and downs, highs and lows. Like many roller coasters, the ride tends to be rougher in the beginning, the lows may be deeper and longer. The difficult periods should become less intense and shorter as time goes by, but it takes time to work through a loss. Even years after a loss, especially at special events such as a family wedding or the birth of a child, we may still experience a strong sense of grief.

Hospice Foundation

Symptoms of Grief.

While loss affects people in different ways, many people experience the following symptoms when they're grieving. Just remember that almost anything that you experience in the early stages of grief is normal – including feeling like you're going crazy, feeling like you're in a bad dream, or questioning your religious beliefs.

- Shock and disbelief - Right after a loss, it can be hard to accept what happened. You may feel numb, have trouble believing that the loss really happened, or even deny the truth. If someone you love has died, you may keep expecting them to show up, even though you know they're gone.

- Sadness - Profound sadness is probably the most universally experienced symptom of grief. You may have feelings of emptiness, despair, yearning, or deep loneliness. You may also cry a lot or feel emotionally unstable.

- Guilt - You may regret or feel guilty about things you did or didn't say or do. You may also feel guilty about certain feelings (e.g. feeling relieved when the person died after a long, difficult illness). After a death, you may even feel guilty for not doing something to prevent the death, even if there was nothing more you could have done.

- Anger - Even if the loss was nobody's fault, you may feel angry and resentful. If you lost a loved one, you may be angry at yourself, God, the doctors, or even the person who died for abandoning you. You may feel the need to blame someone for the injustice that was done to you.

- Fear - A significant loss can trigger a host of worries and fears. You may feel anxious, helpless, or insecure. You may even have panic attacks. The death of a loved one can trigger fears about your own mortality, of facing life without that person, or the responsibilities you now face alone.

- Physical symptoms - We often think of grief as a strictly emotional or spiritual process, but grief often involves physical problems, including fatigue, nausea, lowered immunity, weight loss or weight gain, aches and pains, and insomnia.

Myths and Facts About Grief

MYTH: The pain will go away faster if you ignore it.
Fact: Trying to ignore your pain or keep it from surfacing will only make it worse in the long run. For real healing it is necessary to face your grief and actively deal with it.

MYTH: It's important to be "be strong" in the face of loss.
Fact: Feeling sad, frightened, or lonely is a normal reaction to loss. Crying doesn't mean you are weak. You don't need to "protect" your family or friends by putting on a brave front. Showing your true feelings can help them and you.

MYTH: If you don't cry, it means you aren't sorry about the loss.
Fact: Crying is a normal response to sadness, but it's not the only one. Those who don't cry may feel the pain just as deeply as others. They may simply have other ways of showing it.

MYTH: Grief should last about a year.
Fact: There is no right or wrong time frame for grieving. How long it takes can differ from person to person.

Coping with Grief.

The single most important factor in healing from loss is having the support of other people. Even if you aren't comfortable talking about your feelings under normal circumstances, it's important to express them when you're grieving. Sharing your loss makes the burden of grief easier to carry.

Point 1: Finding support after a loss.

- Turn to friends and family members – Now is the time to lean on the people who care about you, even if you take pride in being strong and self-sufficient. Draw loved ones close, rather than avoiding them, and accept the assistance that's offered. Often times, people want to help but don't know how, so tell them what you need – whether it's a shoulder to cry on or help with funeral arrangements.

- Draw comfort from your faith – If you follow a religious tradition, embrace the comfort its mourning rituals can provide. Spiritual activities that are meaningful to you – such as praying, praying with others, meditating, or going to church – can offer solace. If you're questioning your faith in the wake of the loss, talk to others such as your pastoral counsellor, pastor, minister or someone else in your church community who you feel safe with.

- Join a support group – Grief can feel very lonely, even when you have loved ones around. Sharing your sorrow with others who have experienced similar losses can help. To find a bereavement support group in your area, contact local hospitals, hospices, funeral homes, and counselling centres.

- Talk to a therapist or grief counsellor – If your grief feels like too much to bear, call a mental health professional with experience in grief counselling. An experienced therapist can help you work through intense emotions and overcome obstacles to your grieving.

Point 2: Take care of yourself.

When you're grieving, it's more important than ever to take care of yourself. The stress of a major loss can quickly deplete your energy and emotional reserves. Looking after your physical and emotional needs will help you get through this difficult time.

- *Face your feelings.* - You can try to suppress your grief, but you can't avoid it forever. In order to heal, you have to acknowledge the pain. Trying to avoid feelings of sadness and loss only prolongs the grieving process. Unresolved grief can also lead to complications such as depression, anxiety, substance abuse, and health problems.

- *Express your feelings in a tangible or creative way.* - Write about your loss in a journal. If you've lost a loved one, write a letter saying the things you never got to say; make a scrapbook or photo album celebrating the person's life; or get involved in a cause or organization that was important to him or her.

- *Look after your physical health.* - The mind and body are connected. When you feel good physically, you'll also feel better emotionally. Combat stress and fatigue by getting enough sleep, eating right, and exercising. Don't use alcohol or drugs to numb the pain of grief or lift your mood artificially.

- *Don't let anyone tell you how to feel.* - and don't tell yourself how to feel either. Your grief is your own, and no one else can tell you when it's time to "move on" or "get over it." Let yourself feel whatever you feel without embarrassment or judgment. It's okay to be angry, to yell at the heavens, to cry or not to cry. It's also okay to laugh, to find moments of joy, and to let go when you're ready.

- *Plan ahead for grief "triggers".* - Anniversaries, holidays, and milestones can reawaken memories and feelings. Be prepared for an emotional wallop, and know that it's completely normal. If you're sharing a holiday or lifecycle event with other relatives, talk to them ahead of time about their expectations and agree on strategies to honour the person you loved.

When grief doesn't go away.

It's normal to feel sad, numb, or angry following a loss. But as time passes, these emotions should become less intense as you accept the loss and start to move forward. If you aren't feeling better over time, or your grief is getting worse, it may be a sign that your grief has developed into a more serious problem, such as complicated grief.

Complicated grief

The sadness of losing someone you love never goes away completely, but it shouldn't remain centre stage. If the pain of the loss is so constant and severe that it keeps you from resuming your life, you may be suffering from a condition known as complicated grief. Complicated grief is like being stuck in an intense state of mourning. You may have trouble accepting the death long after it has occurred or be so preoccupied with the person who died that it disrupts your daily routine and undermines other relationships.

Symptoms of complicated grief include:

- Intense longing and yearning for the deceased.
- Intrusive thoughts or images of your loved one.
- Denial of the death or sense of disbelief.
- Imagining that your loved one is alive.
- Searching for the person in familiar places.
- Avoiding things that remind you of your loved one.
- Extreme anger or bitterness over the loss.
- Feeling that life is empty or meaningless.

The thought at this time is that should one be stuck in complicated grief or in one of the stages mentioned earlier for a period of six months or longer it would be advisable to seek help from a qualified therapist or grief counsellor to assist you in overcoming this stage.

Personal Thoughts and Reflections

- **Reflection 1:**
  There is no greater loss than the loss suffered than when we fail to find meaning in the initial loss experienced.
  May I encourage you to find meaning therefore in your loss experienced.
  Grieving that is expressed and experienced has the potential to serve our relationship with God ourselves and others.

- **Reflection 2:**
  We ask because we hurt.
  The journey of grief comes with many questions that may linger for a while to come.
  Answers that are found during this time often leads to more questions.
  Slowly though as we move forward we become more comfortable with having the question without the answer.
  (He himself is the answer)

- **Reflection 3:**
  He will not answer all our questions right now. He will and can quieten our aching hearts with His love. For He himself is our answer.

- **Reflection 4:**
  Some of our greatest victories are found in the midst of some of our greatest defeats.

  Grief is a journey that all of us at some time or another need to go through in our lives, this is not a journey that we can go around or over but a journey that we have to walk through.

- **Reflection 5:**
  We hurt now and may not understand the pain of some of our questions. But God is a redemptive God. This pain to He will redeem.

Psalm 23:4
Yea, thou I walk ***through*** the valley of the shadow of death, I will fear no evil; for thou art with me; Thy rod and thy staff, they comfort me.

Question to consider.
The same rod and staff that comforted and led Jesus through the Garden of Gethsemane can comfort and lead us through ours as well.

The Rod of Humble Submission and the Staff of Blind Obedience will surely be our place of comfort as well.

To be able to say:
Yes, Lord, even though I don't understand you, I will trust in you.

COPING WITH ANTICIPATORY GRIEF

While many of us might think of “grief” as being a response to losing someone we love, grief is actually and can be more complex than that.

Actually grappling with any kind of loss can involve a grief process, even if that loss isn’t exactly tangible.

There’s a lot to be grieving right now with the recent COVID-19 outbreak.

There’s a collective loss of normalcy, and for many of us, we’ve lost a sense of connection, routine, and certainty about the future. Some of us may already have lost financial support, a ministry or even loved ones.

Some us have already fallen ill with the virus and had to deal with the anticipatory grief on how this may or may not end. This is not to mention the sense of community and gatherings that we hold so dear to us as a mission. Social distancing has changed for now the way we greet or embrace one another. All of these are losses felt in this time some more tangible than others.

Still if not all of us, have a lingering sense that more loss is still to come and this might yet still be true. Many have spoken of a grief still to come and what that may or may not look like. These times are hard to quantify, they are indeed unprecedented times. A place where we may feel or believe that we may have little or no control or the fear of losing control even further and in that there is another expression of grief.

This sense of fearful anticipation is called “anticipatory grief,” and it can often be uncomfortable in itself sometimes creating a distressing uncomfortable emotion within with no real certainty of knowing what to do to alleviate some of the distress.

A mourning process can occur even when we sense that a loss is going to happen, but we don’t know exactly what it is yet. We know the world around us will never be the same — but what exactly we’ve lost and will lose is still largely unknown to us. Focusing on what anticipatory grief means is wise and important for us to do at this time, the imagining of what life will be like without is also a key part of the process in coming to terms with this type of grief.

This can be difficult to come to terms with.

If you’re wondering if you might be experiencing this kind of grief, here are some signs to look for, as well as some coping skills you can tap into at this time: It bears mentioning that grief is grief and while there are common signs to this experience of anticipatory grief it may also be experienced differently for different people and cultural groups, influenced by one’s world views, past experiences and kind of relationship had is to mention a few of those determining factors.
Besides anticipatory grief having some of the same emotions felt to normal grief such as anger, anxiety, depression, desire to talk, fatigue, emotional numbness, fear, guilt, loneliness, poor concentration or forgetfulness and sadness it also comes with some of its own indications.

With anticipatory grief, the feelings of loss and pain stem from imagining what life will be like without what we once knew or had or the potential or inevitable loss of a loved one.

Indications of anticipatory grief.

- **You're on edge — and it's not always clear exactly why**
  Maybe you're feeling a sense of dread, as though something bad is just around the corner, but it's unclear what it might be. (This is often described as "waiting for the other shoe to drop.")

  Hypervigilance is also a really common way this shows up. You might be scanning for possible "threats" — for example, reacting strongly whenever someone coughs or sneezes nearby, becoming agitated with a stranger who isn't properly social distancing, or panicking whenever the phone rings.

  This can also manifest as persistent anxiety and overwhelm, like "freezing up" when faced with decision making or planning, or procrastinating more often to avoid complex tasks.

  If you're anticipating danger or doom, it makes sense that staying emotionally regulated would be more challenging right now.

- **You may feel angry at things you can't control.**
  Finding yourself easily and persistently frustrated is a very common manifestation of grief.

  For example, working from home might have previously felt like a luxury, but maybe now it feels more like a punishment. Not getting your preferred brand of boxed macaroni and cheese might not have felt like a big deal before, but suddenly you're irate at your local store for not having ample stock.

  If small obstacles suddenly feel intolerable, you're not alone. These obstacles often serve as unconscious reminders that things aren't the same — triggering grief and a sense of loss, even when we aren't aware of it.

  If you find yourself getting riled up more often, be gentle with yourself. This is a completely normal reaction during a time of collective trauma. Allow yourself time to adjust.

- **You're resigned to the worst case scenario**
  One of the ways that people often cope with anticipatory grief is to try to mentally and emotionally "prepare" for the worst case scenario.

  If we pretend that it's inevitable, we can trick ourselves into thinking it won't feel so shocking or painful when it does come to that.

  However, this is a bit of a trap. Ruminating about morbid scenarios, feeling hopeless as things unfold, or anxiously spinning out about everything that could go wrong won't actually keep you safe — instead, it will just keep you emotionally activated.

  In fact, chronic stress can impact your immune system in negative ways, which is why it's so important to practice self-care during this time.

  Preparedness is important, but if you find yourself fixated on the most apocalyptic and disastrous possibilities, you may be doing more harm than good. Balance is key.

- **You find yourself withdrawing or avoidant of others**

When we feel overwhelmed, fearful, and triggered, it makes a lot of sense that we might withdraw from others. If we can barely keep ourselves afloat, avoiding other people can feel like we're protecting ourselves from their stress and anxiety.

This can backfire, though. Isolation can actually increase feelings of depression and anxiety.

Instead, we need to stay connected to others — and we can do that by keeping firm boundaries about what kinds of support we can offer.

Some examples of boundaries you could set right now:

1. I've been having a really hard time with this COVID-19 stuff. Can we keep the conversation light today?
2. I don't think I can talk about this right now. Is there something we can do to distract ourselves right now?
3. I'm struggling at the moment and not able to support you in that way right now. I'm happy to (play a game/send a care package/check in by text later on) instead if that would be helpful.
4. I don't have a lot of capacity to support you right now, but I'll email you some links later on that I think could be useful if you'd like that.

Remember, there's nothing wrong with setting whatever boundaries you need to take care of yourself!

- **You're completely exhausted**
  A lot of what we're talking about with anticipatory grief is really just our body's trauma response: namely, being in "fight, flight, or freeze" mode.

  When we feel threatened, our bodies react by flooding us with stress hormones heightening our sense of alertness, just in case we need to react quickly to a threat.

  One of the side effects of this, though, is that we end up feeling worn down. Being so activated on a daily basis can really tire us out, making exhaustion a pretty universal grief experience.

  This is particularly difficult at a time when so many people are talking about how productive they've been while self-isolating. It can feel pretty lousy to hear about others starting new hobbies or projects while we can barely get out of bed.

  However, you're far from alone in your pandemic-induced exhaustion. And if all you can do right now is keep yourself safe? That's more than good enough.

If you're feeling anticipatory grief, what can you do to cope?

- **Validate and affirm your feelings.** There's no reason to feel ashamed or critical of the emotions you're having. Everyone will experience grief differently, and none of the feelings you're having are unreasonable during such a difficult time. Be kind to yourself.

- **Bring it back to basics.** It's especially important to stay fed, hydrated, and rested at this time. Prioritize staying connected over been "informed." Try not to set the rules and accept the fact that you may still get sick.

- **Connect with others,** even when you don't want to. It can be tempting to shut everyone out when you're overwhelmed and activated. Please resist the urge! Human connection is a critical part of our well-being, especially now.

- **Prioritize rest and relaxation.** Yes, it sounds absurd to tell people to relax during a pandemic. However, when our anxiety is so activated, it's critical to try to deescalate our bodies and brains.

- **Express your pain.** Find an outlet for your feelings, whether it's a trusted family member or friend, a spiritual adviser, an in-person or online support group, or some other way of expressing yourself, like artwork, journaling or meditation.

- **Take care of your emotional and physical health.** Combat the anxiety and stress of anticipatory grief by staying physically healthy. Besides getting enough exercise, nutritious food and sleep, attend to your spiritual needs as well, through long walks, meditation, prayer or whatever works for you.

- **Allow yourself to experience the effects of grief.** Resisting these feelings or emotions can in itself serve to complicate the grief felt and increase anxiety levels. These emotions felt are neither wrong nor right but they are real. Learning to find a place of rest in in Him in the midst of the grief felt can indeed assist. Honesty and self-awareness to the losses felt and found and finding a healthy way to communicate them with others can not only serve you but also others in their pain.

- **There is always something to be found in grief.** Grief is never an entity in itself. It is not all about loss or losing. It is also about change and integration. As in case scripture is specific to leaving and cleaving. It is not just about letting go it is also about attaching to something new. The one just simply cannot truly happen without the other.

  Oh for the grief that God the Father and Jesus must have felt over the fall of mankind and in the journey to and of the cross. This grief felt and travelled in brought to them a way back for us to them. The salvation of mankind.

- **Celebrate that which you find.** Whether it be a new found skill, talent, serving gift or whatever. Try not to let the pain felt over the loss experienced minimize the new things that come from such a deep journey.

Steadfastness in the Lord in the midst of these difficult and perplexing times of grief felt.

1 Peter 2: 19-25.

- There is a suffering that is commendable unto God. That is when we bear up under the pain of unjust suffering because we are conscious of God.
- Let us try and respond in these difficult times as He responded.
  Vs 23 "When they hurled their insults at him, he did not retaliate; when he suffered, he made no threats. Instead, he entrusted himself to him who judges justly." Let us respond in kind when we find ourselves on the short end of the suffering or grief of another whether projected or not. Grief often does not look pretty. It's often sometimes messy and one finds it hard to regulate ourselves emotionally.
- Vs 25. "He is the Shepherd and Overseer of our souls.

Acts 2:42

- The early church in the midst of their trials devoted themselves to four attributes of the Christian faith. Teaching of the apostles, Fellowship, Breaking of Bread and Prayer.

Psalm 23.

I recommend that we take time to read through this chapter of scripture meditating all the while on who He wants to be and who He assigns Himself to be as he can do because He is Lord. "The Good Shepherd"

The other truth is that there can be sadly many shepherds in our life. He wants to be that Good Shepherd and Overseer of our souls.

- Vs 6. “And I will dwell in the house of the Lord forever.”
  Dwell here means to rest, to be at peace, content.

I shall therefore end this in a prayer.
“Father may the grief felt by your saints in this difficult time whether it be anticipated or actual, may it to find a place to rest in your house and may you quite the distress felt in their hearts with your love, for in their distress you too are distressed. Thank you Lord that you are not indifferent to their distress felt and neither are you intimidated by it but that you oh so fully identify with us. May it be Lord with the comfort that we receive be able to in turn comfort others. Amen.

CHILD ABUSE ALLEGATION AND LEADERS/STAFF RESPONSE.

It has been challenging to write a document that may serve us a mission globally. This document is not intended to replace or supersede the law of your nation. Please do familiarize yourself as to your nations legal guidelines obligations that you may have.

Definition of Child Abuse.

Child abuse and neglect consists of any acts of commission or omission by a parent, caregiver or other adult that results in harm, potential for harm, or the threat of harm to a child (0-18 years of age) even if the harm is unintentional (Gilbert et al., 2009). Child abuse and neglect can be in the form of physical abuse, sexual abuse, emotional abuse, neglect, and witnessing domestic violence.

CFCA Resource Sheet— September 2014

Should a child or minor confide in you regarding a hurtful experience involving abuse please bear in mind that the child or minor would not have done so should he or she not have considered you a safe person to do so with. Your continued support and place of safety while trying to ensure she or he gets the right help needed would be an important and a needed continued role to play until the situation has been rightfully and properly addressed. The precedence should be to believe the child until otherwise proven differently.

Responding to a Child Disclosing Abuse

- believe the child
- reassure the child that telling you was the right thing to do
- maintain a calm appearance
- find a quiet place to talk with the child
- be truthful
- listen to the child and let them take their time
- let the child use their own words to tell you what happened
- let the child know what you will do next
- do not confront the person alleged to be the abuser
- be respectful of the sensitive nature of the information and only discuss the child's situation with professionals, your leader or appropriate authorities.
- Do not encourage the child to confront the abuser/perpetrator
- if possible write down what the child has said.

The Perpetrator.

Perpetrators can be good at hiding the violence, publicly presenting as kind, loving, charming and likeable, but behave in cruel, violent, undermining and manipulative ways in private.

They are not those scary men who lurk around playgrounds looking for opportunities. In fact, according to the Crimes Against Children Research Centre, 90% of children who are sexually abused know their perpetrator.

They use very manipulatives means to get the child to keep the secrecy. Such as threats or intimidation. They would also try to imply that what they are doing is normal or necessary for certain reasons.

They often use fear or embarrassment to keep a child from telling another person about the abuse. They may use statements such as, "No one will believe you," or threaten them with danger (or danger to someone they love) to keep them from telling. Other examples "I love playing with you, but if you tell anyone else what we played they won't let me come over again." Or it can be a threat: "This is our secret. If you tell anyone I will tell them, it was your idea and you will get in big trouble!

It is always an emotionally unsafe place for a child to continue to be around the perpetrator.

Allegation of Abuse from Family Member.

- Try and obtain as many of the facts as sensitively as possible from the child. Such as child's name and surname, whom, when, what and how often has it happened and who else has the child told.

- Inquire if the child feels safe in informing any other family member, such as a parent, aunt, uncle etc. Involve any other person if appropriate that the child may have told if they are an authority figure, such as an adult etc.

- **If the child consents to inform a family member.**
    - Try and establish how safe the child may or may not feel with the family member.
        - Ask how safe the child feels with this person? Do they think that they will listen and believe the her/him? Inquire if the child thinks or believes that the person may or may not get angry with her/him afterwards for what they have told, said or done. If the child is of the thought that the family member may not listen, believe or get angry with the child then try and advise the child that this may not be the right person. Try and then establish with the child another person with whom there is this safety.
        - Inquire if the child would prefer for you to accompany them. If so you may have to explain to the person on why you may be present. "That Mary "child's name" has confided in you on a potential serious matter and has asked me to please help her let you know about it. The child may choose to share herself in your company or for you to speak in the child's company. If you speak, speak in a language that the child understands and follow up with adult talk afterwards if needed.
        - In the event that he or she prefers not to be present, explain to them briefly what you might tell the other person and ask if that is okay. Also give the option if the child may want to join the conversation later.
        - Inform the family member on what the law might require in this regard. In many cases it must be reported.

- **Should the child not want to inform a family member.**
    - Reassure the child that they have still done the right thing and that which has happened to them is wrong.
    - Offer for the child to go with you to another appropriate person. This should be a social worker, school counsellor, school principal, child care protection services, police etc. Should the child decline, reassure the child gently again that it is the right thing and that you would need to let someone know who can ensure that it does not have to happen again to them.
    - Be most mindful that the child may be scared, frightened etc. It is not uncommon for the child in an abusive situation to try and be protective of the perpetrator and not want to involve others. The child may also have been threatened or manipulated by the perpetrator to keep silent.
    - Should the child still not consent it would then be important for you to follow up in your own capacity possibly without the child's knowledge with the necessary authorities to inquire on further advice and assistance.

- Should you at any point be concerned for the child's immediate safety it would be advisable to contact social services or other authorities if in the event that it is considered that the child should need to be removed. Try and not do this though outside of the knowledge of the parents or appropriate family.
- Membercare/Counselling may need to be provided for the child and family to assist them in working through this.

Do not neglect to keep your base leader or base leadership team informed of the situation and what you may or may not be planning to do.

Where an allegation of substance has been made that a staff, student, short-term volunteer or visitor has abused a child, the following processes should be applied.

- Should the staff member, student, volunteer still be on base, immediate action must be taken to further protect the child and to ensure the child's continued safety.
- In the light of the fact that the precedence of society and even our community in these situations is to believe the child until otherwise proven differently it is strongly recommended as a precautionary measure that the person against whom the allegation is made step down from any form of leadership, ministry until as such time that a process has been able to be applied to the allegations made. If the matter is fitting and justified the person concerned should be asked to leave the community. Be careful in this not to implicate the person in anyway but that it is the onerous and integrious thing to do in the light of the situation.
- The alleged should be considered innocent until proven guilty such a due process should be carefully explained to him along with reason's. Supportive care and council should also be provided for if the alleged requests and requires such.
- Allegations should be taken back to the family informing them of what has come to light and the precautionary steps taken.
- Inform the family that they are totally within their right and means to take further legal action, or to seek further legal counsel and supportive therapy for their child. The family members should also be advised if the local jurisdiction requires of one to report such allegations. Some form of membercare/counselling should also be offered to the family. There would be a lot for the family to process with many varying and often powerful emotions to work through.
- It should not be perceived observed or interpreted in any way that YWAM would have stood in the way of such. We should be most careful in this situation as to not give undue influence.
- The YWAM Community must apply themselves to any investigation.

Furthermore,

- The team leader, location leader or base leader must be advised as to the allegations. In situations where this would be inappropriate the alleged abuse should be reported to the Area Circle Leader.
- It is highly recommended that a full report be compiled documenting the investigation, findings, and response or action taken. This should be completed within 30 days. Outside expertise or legal authorities may be involved. The report must be made available to the Area Circle Leader.
- The Area Circle Leader must be advised as to all child abuse allegations and if necessary where a staff member may be involved to advise the Regional Eldership. Priority should be given to this communication.
- If some of the allegations are found to be true in any way, it is strongly recommended that the help of an impartial team be enlisted. This could include child care services, community leaders, Pastor's or any legal authority. This would serve to minimize any allegation of a cover-up until the investigation is concluded. ALWAYS INSURE THAT ALL SIDES OF THE STORY ARE HEARD;
- It is highly advisable that the allegation be kept confidential, with only those directly involved having the appropriate information;
- Social Services and/or Child Care Services should be involved for further emotional support, counselling and legal processes, where appropriate;
- Should penetration be suspected, the assistance of a Medical Doctor or of the District Surgeon must be provided for in consultation with the Parent/Guardian. This is highly recommended due to medical or other health implications.
- It is important that both victim and perpetrator be treated with respect from the start of the process to the end;
- Any accusation of abuse that a child brings MUST be taken seriously and not dismissed in any way. The alleged perpetrator should be treated without prejudice;
- Someone should be appointed to deal with media, social media and police in the event of.
- Should information need to be communicated to the wider community, it would be wise to communicate with the parents/legal guardian about what could be said/not said.
- Where no evidence of abuse has been found, the informant, and all involved will be notified. Debriefing of a falsely accused person should be provided for and a possible process of reintegration to the community would need to be explored.

RAPE AND SEXUAL ASSAULT OFFENCES GUIDELINES.

Guidelines to immediately after a sexual assault

1. **Get to a Safe Place**
   Do this as soon as possible.

2. **Tell someone**
   It may be very difficult for you to tell someone what has happened to you, but it's important because this person can support your story and back you up in court.

3. **Do not wash yourself**
   There might be hair, blood or semen on your body or clothes that can be used as evidence of the rape.

4. **If you are injured**
   Go straight to a hospital, community health centre or doctor.

5. **Report the rape**
   If you want to report the rape, go to the police station nearest to where the attack took place as soon as you can. Ask a friend or family member to go with you for support. Keep the name of the police officer in charge of your case and your case number.

6. **If you're afraid**
   If you fear retribution or intimidation by the rapist/s, make sure the police are aware of this and ask that the rapist/s be not allowed out on bail.

7. **Forensic examination**
   A doctor will examine every part of your body to find and collect samples of hair, blood or semen. This is part of the police investigation to gather medical evidence of the crime.

8. **Get support**
   Ask for pamphlets or booklets on rape and the number of a local counselling service to give you further support and advice about the police matter, court case and any other effects of the rape.

9. **Get treatment**
   Whether or not you want to lay a charge, make sure that within 72 hours that you have sought treatment:
   - You may be advised to take The Morning After Pill (MAP) to prevent pregnancy. Remember that this is your choice and you have the right to refuse such treatment. Ensure that you receive the right council in this regard.
   - An HIV test and antiretroviral treatment to prevent HIV infection;
   - Antibiotics to prevent a Sexually Transmitted Infection (STI).

Immediate Emotional Support if staff, student or a significant other in your life has survived a sexual assault.

He or she may need your support to move forward. Keep these tips in mind:

- Listen to and believe the survivor. Affirm the survivor's decision to confide in you.
- Help the survivor understand that the sexual assault was not their fault.
- It's natural to feel anger, helplessness, grief, or sadness. It is helpful for you to deal with these emotions so that you can be an effective support person.
- Educate yourself about the survivor's options. This will help clear confusion for both of you, and promote faster healing and recovery.

Physical Symptoms of Rape Trauma Syndrome

Physical symptoms are those things which manifest in or upon the survivor's body that are evident to her and under physical examination by a nurse or doctor. Some of these are only present immediately after the rape while others only appear at a later stage.

- Immediately after a rape, survivors often experience shock. They are likely to feel cold, faint, become mentally confused (disorientated), tremble, feel nauseous and sometimes vomit
- Pregnancy
- Gynaecological problems. Irregular, heavier and/or painful periods. Vaginal discharges, bladder infections.
- Sexually transmitted diseases
- Bleeding and/or infections from tears or cuts in the vagina or rectum
- A soreness of the body. There may also be bruising, grazes, cuts or other injuries
- Nausea and/or vomiting
- Throat irritations and/or soreness due to forced oral sex
- Tension headaches
- Pain in the lower back and/or in the stomach
- Sleep disturbances. This may be difficulty in sleeping or feeling exhausted and needing to sleep more than usual
- Eating disturbances. This may be not eating or eating less or needing to eat more than usual

Behavioural Symptoms of Rape Trauma Syndrome

Behavioural symptoms are those things the survivor does, expresses or feels that are generally visible to others. This includes observable reactions, patterns of behaviour, lifestyle changes and changes in relationships.

- Crying more than usual
- Difficulty concentrating
- Being restless, agitated and unable to relax or feeling listless and unmotivated
- Not wanting to socialise or see anybody or socialising more than usual, so as to fill up every minute of the day
- Not wanting to be alone
- Stuttering or stammering
- Avoiding anything that reminds the survivor of the rape
- Being more easily frightened or startled than usual
- Being very alert and watchful
- Becoming easily upset by small things
- Relationship problems, with family, friends, lovers and spouses
- Fear of sex, loss of interest in sex or loss of sexual pleasure
- Changes in lifestyle such as moving house, changing jobs, not functioning at work or at school or changes to appearance
- Drop in school, occupational or work performance
- Increased substance abuse
- Increased washing or bathing
- Behaving as if the rape didn't occur, trying to live life as it was before the rape, this is called denial
- Suicide attempts and other self-destructive behaviour such as substance abuse or self- mutilation

Psychological Symptoms of Rape Trauma Syndrome

Psychological symptoms are much less visible and can in fact be completely hidden to others so survivors need to offer this information or be carefully and sensitively questioned in order to elicit them. They generally refer to inner thoughts, ideas and emotions.

- Increased fear and anxiety
- Self-blame and guilt
- Helplessness, no longer feeling in control of your life
- Humiliation and shame
- Lowering of self esteem
- Feeling dirty or contaminated by the rape
- Anger
- Feeling alone and that no one understands
- Losing hope in the future
- Emotional numbness

- Confusion
- Loss of memory
- Constantly thinking about the rape
- Having flashbacks to the rape, feeling like it is happening again
- Nightmares
- Depression
- Becoming suicidal

It is important that we recognise that people respond differently to trauma. While most survivors will experience these symptoms, some survivors may only experience a few of these symptoms or none at all. We must be careful not to judge whether someone has been raped by the number of symptoms that they display.

The trauma of rape is often compounded by the myths, prejudice and stigma associated with rape. Survivors who have internalised these myths have to fight feelings of guilt and shame. The burden can be overwhelming especially if the people they come into contact with reinforce those myths and prejudices. It is never a survivor's fault for being raped. No one asks to be raped or deserves to be raped.

KIDNAPPING/HOSTAGE

Attack Recognition and Prevention with Guidelines If Taken Hostage
Guidelines to Managing a Hostage Crisis.

Criminal Attack Vs Terrorist Attack

Definitions:

1. A criminal attack is an act of violence, perpetrated against another for a variety of reasons, in violation of federal or state statutes.
2. Terrorism is the unlawful use of force or violence against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political, social, or religious objectives.

While both acts are considered criminal, there is a significant difference between criminal attacks and terrorist attacks.

Criminal Attacks

1. Criminals usually select their victims at random.
2. Criminal attacks are usually “crimes of opportunity” committed at a moment's notice or as the situation allows.
3. Criminal attacks are usually not well planned.
4. Criminals do not usually “train” for their attacks. They may have experience from other criminal acts, but they do not train for them.
5. In most cases of criminal attack, the attack site is not pre-chosen. Criminal attacks usually occur on the spot and out of the mainstream, where the crime will not be observed.

Terrorist Attacks

1. Terrorists, on the other hand, usually plan their attacks.
2. Terrorists carefully study and select their targets (victims) ahead of time.
3. Terrorists practice their attacks. There is usually a “dry run” before the actual attack, similar to a military assault.

Note: History reveals that once attacked by terrorists, the victim has little chance of thwarting the attack.

Five Phases of a Terrorist Attack

Analysts, of terrorist attacks, report a pattern regarding each event. In fact, it may be described as a sequence of events. The sequence is as follows:

Target Selection

In the Target Selection phase the terrorists initially look at several targets. They usually choose the target with the greatest ratio for success. Some of the criteria for target selection include:

1. The one with the greatest “value,” such as the organization’s director.
2. The one most vulnerable, that is, the one with the fewest security measures.
3. The one most predictable (routine).

The one chosen is considered the “soft” target.

Target Intelligence

All terrorists need information to carry out their threats. Information is gathered through surveillance. In other words, they watch you! The information they seek includes:

1. Your habits
2. Your daily itinerary
3. Your routine
4. The routes you take to and from work
5. The security measures you employ, such as access to your residence, car park, etc.

Note: The target intelligence phase may be the one and only time they reveal themselves and, if alert, you can identify them and prevent the attack.

Operational Planning

After the target is selected and intelligence has been gathered, the terrorists choose the attack site. They choose the attack site, or "kill zone," on information you have provided during their surveillance. It will usually include tactical advantages such as:

1. A place with "high ground" for snipers.
2. A place that is conducive to the element of surprise.
3. A place that has a good escape route.

Once the site has been chosen, the terrorists practice their attack against you through a series of "dry runs" so they are familiar with how things will proceed.
Each dry run is timed. The terrorists want to complete the entire attack in less than 20 minutes.

Attack Site

At the time of attack, the target has somewhere between 2-5 seconds to recognize the attack and respond. The time starts just prior to your entry into the "kill zone." It starts with the terrorists "identifying" you to the others (pointing at you or radioing to others that you are present). Once this process begins, you have very little time to react and most people react by playing the role of a "victim" (stunned and unable to react).

Escape and Exploitation

At the close of the attack, the terrorists escape via the planned routes. Once safely away, they are free to exploit the situation by claiming their "great success" or by demanding ransom in kidnapping situations.

Soft Targets

It should be noted that terrorists are switching their tactics. With the embassies and military targets employing tighter security measures, the terrorists are switching to "soft targets" or those targets with few security measures, such as restaurants, nightclubs, hotels, and residential compounds. Specific groups of people are being targeted more now too; groups such as humanitarian aid workers and missionaries.

Defeating The Attack

Victims have little chance of stopping the attack once it has begun, so prevention is the key! The best way to defeat the terrorist is to deny any one of the five phases of an attack. Have a plan and be extremely unpredictable!
To accomplish this, one must use aggressive security planning and tactics.

1. Find the terrorists before the attack, when they are most vulnerable, during the surveillance or "target study" time.
2. Always be on the lookout for the pre-attack deployment of the suspects.
3. Vary your routes and routines. This is an absolute must!
4. Conduct surveys of routes you take on a regular basis for possible target spots.
5. Be alert when driving and approaching choke points (attack sites). Be alert for pre attack indicators:
    a) Look for abnormal activity
    b) Look for people in disguise
    c) Look for someone identifying you to others

6. Destinations - Survey your destination upon arrival.
    a) Look for the unusual, anything that appears out of place.
    b) Look for people who "do not fit" the surroundings or the occasion.
    c) Look for people in disguise (wearing a long coat in warm weather)

7. Situational Awareness is paramount! Be diligent in the awareness of your surroundings.

8. If attacked:
    a. Be prepared to employ the evasive manoeuvres you plan ahead of time.
    b. Use passive resistance, such as hugging a telephone pole or laying "spread eagle" on the ground and making your body stiff.
    c. Act quickly and do not hesitate!

Guidelines If Kidnapped by Terrorists:

Our staff or students can get abducted for a variety of reasons, such as grievances over the organization's programs, politics, terrorism, ransom, and sometimes for a combination of these reasons. Sometimes the motives will change, for example, hostage situations may start out as politically motivated, but during the course of the situation, it may turn into a ransom kidnapping. Regardless of the abduction cause, most hostages stand a good chance of surviving the ordeal if they follow some simple rules.

Initial Response Procedures

In the event a staff member or student been abducted:

1. Keep off all social media

2. Immediately notify the local authorities, the appropriate embassy, local church leaders, the Area Circle Eldership/Leadership.

3. Contact the immediate family of the hostage(s) on the field. Contact must be made in person if at all possible. Should the family members not be on the field but at another location or country, request the help of the abductee's or families Pastor, Community Leader or relevant people of authority. Try and avoid the initial contact been by phone or email where possible. Provide the necessary informant with contact details to which the family can make contact with you.

4. During contact with the family:
    a. Advise them a member of their family has been taken hostage.
    b. Advise them their family member is safe and unharmed (if known)
    c. Advise them that everything possible is been done to secure the release of their loved one.

5. A Crisis Management Team and or Field Crisis Team should be formed with the following possible representative of people and skill sets. Enlisting the help of a hostage negotiator may also be required. This team may have to be operational for a long term.
    a) The team should be strongly locally represented or have good two-way communication with them. Relationship of trust is strongly advised.
    b) Intercessory.
    c) Communications along with dealing with the media and media research.
    d) Membercare, Pastoral.
    e) To minimize our own security risk it is strongly advisable to invite leaders of the local community, churches or other similar aligned organizations to be a part of the team and decision making processes.
    f) The role of the team should not be primarily investigative but of a supportive nature to the authorities and of care for the family and remaining colleagues on the field. The team may however be called upon to carry out certain investigative assistive roles.

6. DO NOT REVEAL ANY STRATEGIES THAT ARE BEING DEVELOPED OR DEPLOYED.

7. Arrange for someone to make daily contact with the family to provide them with updates and support. If the family is in any danger, arrange for them to be moved to a safe place. Usually family members will be relocated to their home country for adequate care and support. Likewise, should apply for work colleagues and other staff or students.

8. Choose one local person to act as a mediator in the event the hostage taker(s) calls the office. Choose someone known as a good conversationalist and fluent in the local languages. In some instances, this may require having more than one person available because of multiple languages in the area and the time involved. If one of these persons is contacted by the Hostage taker(s):

    a. Advise the caller that you are manning the phones and that you have no authority to make any offers.
    b. Also advise the caller that you are trying to contact the person who has authority, but have not yet been able to do so as yet. Or, tell the caller you are in contact with the person of authority and can relay messages. In other words, STALL for time.
    c. Be sympathetic with the hostage taker(s), but do not make them feel they did the right thing.
    d. Listen carefully to everything the hostage taker(s) has to say. If possible, record the conversation.
    e. Determine if you can.
        - Who is being held hostage.
        - Why they are being held.
        - What the hostage taker(s) are demanding.
        - The health and safety of the hostage(s). Ask to speak with them.
        - If you are allowed to speak with them, tell them that everything possible is been to help them. Do NOT say anything you do not want the hostage takers to know because they will be listening in on the conversation.
        - Suggest the release of all hostages as a humanitarian offer.
        - Ask for the release of any women and children.
        - STALL FOR TIME!

9. Choose one person to deal with the media who will be cooperating with the Crisis Management Team's instructions.

Hostage Survival

Knowledge is one of the key factors in surviving a hostage situation. Former hostages have articulated this fact, stating that the lack of knowledge concerning their future
and what is being done to secure their release was paramount during captivity.

Each hostage situation is different; some basic similarities exist. Similarities to keep in mind:

1. Expect to be blindfolded.
2. Expect to be drugged. This is usually done to keep you quiet and may be to your benefit during the initial phase of the abduction.
3. Expect a long ordeal. Hostage situations are either short in duration or very long, lasting weeks or months, and sometimes a year or more.
4. Know that the two most dangerous times of a hostage situation are those during the initial abduction and those at the time of release, especially if it is a release involving a rescue.

There are four basic phases to each hostage situation and each phase requires the abducted person to follow certain do's and don'ts:

1. Capture Phase: The capture phase is that time in which the individual(s) are initially abducted.
    - Try to keep calm.
    - Obey orders
    - Do NOT speak unless spoken to.
    - Do NOT whisper to colleagues.
    - Do NOT offer suggestions.
    - Do NOT argue.
    - Do NOT make any sudden moves. Ask first.
    - Do NOT be humorous.
    - Try not to give up any personal identification.
    - Try not to allow the covering of your head. This dehumanizes you and makes it easier for the captors to dispose of you at will.
    - The first hour is the most dangerous. Do your utmost to maintain your composure.

2. Transport and/or Consolidation Phase: The time during which the hostage is transported to a place of confinement.
    - Be patient.
    - Try to rest. You will need it.
    - Be polite to your captors. Treat them with respect.
    - Develop a rapport with your captors. This helps remind them of your humanity and makes it a little more difficult to randomly dispose of you.
    - Listen well. Do not argue.

3. Confinement Phase.
    - Keep physically active. Exercise.
    - Keep mentally active. Read, write or play mental games.
    - Get appropriate amounts of sleep.
    - Do not reject food. Keep up your strength.
    - Keep track of time.
    - Do not despair. A lot of people will be working on your release.

4. Termination or Release Phase. This is the time a rescue is attempted or the hostage takers give up on their efforts.
    - If the release is negotiated, follow all commands to the letter.
    - If the release comes as a result of a rescue attempt, follow the guidelines in this section.

Building Rapport: As previously stated, it is important to develop a rapport with your captors. It is much more difficult to kill someone you "know," than it is someone you don't know or someone who has been dehumanized by total seclusion or simulated seclusion effected by covering the captive's head with a cloth bag.

1. Converse with your captors as often as possible.
    - Talk about your family, especially your mother.
    - Insist on your impartiality as a humanitarian worker.
    - Talk with your captors about your human needs, such as hunger, thirst and the need to relieve yourself.
    - Don't beg or plead with your captors.
    - Don't discuss politics or religion with your captors.
    - Don't ask their names or anything that would positively identify them.

2. Don't give away your personal belongings, like your watch, glasses or a ring unless the item is demanded.

3. Always face your captors.
    - Try to memorize facial features without being obvious.
    - Listen for names in their conversations. Commit them to memory.
    - Try to learn something peculiar to each captor, such as a scar, a nervous habit, etc.

4. Be aware of the "Stockholm Syndrome," a situation where captives empathize with their captors and their interpretation of the hostage incident. Patty Hearst suffered from the Stockholm syndrome, even to the point where she took up arms and sided with her captors. Keep your identity intact.

5. Physical and Mental Health: Maintaining your physical and mental health is extremely important during a hostage situation. You may need it to escape should the opportunity present itself or during the rescue attempt.39
    - Keep track of time and days.
    - Keep a daily routine. Try to structure your life in some way.
    - Practice physical exercises, even if it's just isometrics.
    - Drink plenty of fluids. It is common to become dehydrated in hostage situations.
    - Stay well-groomed and as clean as possible.
    - Think positive. Focus on pleasant memories, such as your family.
    - Don't lose faith in your eventual release. Your captors may inform you of false release dates just to dishearten you.

6. Remember that you may be subjected to humiliating and terrifying experiences, such as mock executions, which result in the inability to control your bladder or your bowels. This is normal and others have suffered similar degradations. It's okay.

Communicating and Negotiating:

THIS IS NOT YOUR JOB! Let the experts deal with it. The objective of negotiating is to stall for time. Time wears down the captors and usually results in a happy ending.

1. Be prepared to speak on the telephone or radio. Say only what you are told to say, unless you have a prearranged code word that works into the conversation. Don't force it.
2. If you are captured in a group, choose a spokesperson.
3. Avoid being drawn into the negotiating process.
4. If it is impossible to stay out of the negotiating process, be extremely careful to explain everything in detail with accuracy.
5. If you are presented to a member of the press, keep in mind that they are not there to affect a rescue. They are there for a headline story.

Escape:

Making a decision to escape is entirely up to you, but remember, it is extremely dangerous.

1. Escape is a primary consideration if you are convinced your captors plan to kill you.
2. Remember that you may be endangering other captors if you escape, regardless of your success.
3. Weigh the odds:
4. Count the number of captors and their weapons.
5. Consider the location of your room in the building.
6. Consider the location of the building, if known.
7. Consider the layout of the land especially in desert like terrain. Gather information discreetly.
8. Try to determine if captors are outside as well as inside.
9. What will you do if you make it out of the building?
10. Consider the weather.
11. Are you familiar with outdoor survival?

12. Are you prepared mentally and physically?
13. Are you willing to accept the consequences of failure or recapture?
14. Think positively. Don't give up easily.

Rescue:

Remember this is one of the most dangerous of situations. Police consider the preservation of life in hostage situations as their primary objective. Rescue is a last resort chosen only when the situation deteriorates to the point where lives will be lost if it is not attempted.

1. When an assault occurs, there will probably be a series of blinding and deafening explosions to stun the captors. More than likely, tear gas will be employed and there will be a tremendous amount of confusion. If you are mentally prepared for this, you stand a better chance of survival.
2. Before the assault begins, make a plan. Find the best hiding spot in the room.
3. Preferably one that is behind a protective object that will offer concealment and cover from shrapnel and bullets.
4. As the assault begins, get down immediately.
5. Immediately obey any orders given by the assault forces.
6. Do NOT pick up any weapons discarded by your captors. You will be shot!
7. Identify yourself to authorities as someone who poses no threat, put your hands on your head or in the air.
8. Do everything possible to avoid changing your clothes with the clothes of your captors.

SUICIDE: FIRST AID RESPONSE GUIDELINES TO THREATENED SUICIDE.

Guidelines for Assisting Someone Threatening Suicide

1. Compassion
   - Talk openly and matter of factly about suicide;
   - Show interest;
   - Don't act shocked.
2. Listen
   - Allow them to express their feelings and affirm their feelings. *People who feel suicidal don't want answers or solutions. They want a safe place to express their fears and anxieties, to be themselves(befrienders.org);*
   - Don't be judgmental;
   - Don't debate right or wrong of suicide;
   - Be careful about theological discussions.
3. Assurance
   - Offer hope that alternatives are available but do not insincere or shallow reassurance;
   - Offer to stay with them.
4. Safety
   - Never leave a person alone who has a suicide plan or has attempted suicide before;
   - Arrange for someone to stay with the person;
   - With help of family friends or caregivers make sure you remove danger items (guns, medicine, knives, etc.)
5. Support
   - Offer to contact family or friends, significant others as mentioned previously;
   - Offer assistance in a critical situation (broken relationship, work, etc.)
6. Inform
   - Inform your immediate leader immediately;
   - Inform family or support group.
7. Connect
   - Get them connected with appropriate mental health personnel;
   - Don't be sworn to secrecy;
   - Offer to accompany him or her to mental health personnel.

Goals for Assisting
"A CLASSIC response"

C Compassion
L Listen
A Assurance
S Safety
S Support
I Inform
C Connect

Indicators that Someone May Be Considering Suicide

- Verbal clues
  - "I wish I were dead"
  - "People would be better off without me"
  - "I'm going to end it all"
  - "What's the point of living?"
  - "Who cares if I'm dead anyway?"
  - "Soon you won't have to worry about me"
- Has trouble eating or sleeping
- Shows dramatic changes in behaviour
- Withdraws from friends and/or social activities
- Loses interest in hobbies, work, school, etc.
- Prepares for death by making out a will or makes final arrangements
- Gives away prized possessions
- Takes unnecessary risks
- Talks & thinks about death and dying
- Loses interest in their personal appearance
- Increases their use of alcohol or drugs
- Cries a lot

Increased Risk of Suicide

- Previous suicide attempts
- History of depression & alcoholism
- Suicide plan
- Available means of suicide (meds, guns, knives, etc.)
- Lack of supportive family or friends
- Lack of communication with family
- Unsupportive or abusive family

What they want

- Someone to listen
- Someone to trust
- Someone to care

What they don't want

- To be alone
- To be advised
- To be interrogated

Care for the people around the incident:

- Make sure communication is very clear and does not leave room for speculation or confusion;
- Debrief people involved in the incident within 72 hours. A suicide is a critical incident and requires debriefing from trained people. Please contact either local professionals or the member care circle for help;

- Be aware that an attempted suicide can have a “ripple effect” on others, especially mindful of those who may be psychologically or physiological vulnerable.

Later – after the crisis:

- Review how the crisis was handled. What have you learned? What went well? What would you do differently another time?

Legal issues

Different countries have different legal requirements in regards to suicide and who must be involved if a suicide attempt happens. In some nations it is a crime. In another nation it is a crime if you send someone home after a suicide attempt. Make sure you know the requirements in the country and that such is complied with.

Thoughts on accepting staff and students:

- Take the application process serious. Carefully read the application and references. If they are not clear DO ask questions. Be aware that we cannot accept people with major psychological issues and illnesses as staff or students;
- Make sure EVERY staff and student has valid health insurance that covers them both locally and also in possible outreach locations, covering both emergency situations as well as ongoing treatment and hospitalization;
- In your application forms include a question about psychological/psychiatric health issues. Check what is allowed to be asked legally in your country. This varies from nation to nation.

TOWARDS AN IMPROVED AWARENESS OF SUICIDE.

Youth With A Mission
Best Practise.
Document 1.

The purpose of this document Document 1 “Towards an Improved Awareness of Suicide is to create awareness of suicidal thinking and best practice for management. The following document Document 2 “Suicidal Inquiry - Assessing Someone Who May Be At Risk Of Suicide” is to assist in risk assessment.

Suicide in today’s society has reached epidemic proportions. The World Health Organisation (WHO) revealed in 2017 that no fewer than a million people die annually from suicide, which represents a global mortality rate of 16 people per 100,000 or one death every 40 seconds, and an attempt is made every 3 seconds.

While the link between suicide and mental disorders (in particular, depression and alcohol use disorders) is well established in high-income countries, many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship break-up or chronic pain and illness.

In addition, experiencing conflict, disaster, violence, abuse, or loss and a sense of isolation are strongly associated with suicidal behaviour. Suicide rates are also high amongst vulnerable groups who experience discrimination, such as refugees and migrants; indigenous peoples; lesbian, gay, bisexual, transgender, intersex persons; and prisoners. By far the strongest risk factor for suicide is a previous suicide attempt.

World Health Organization

One in every ten teenage deaths is as a result of suicide while four in every ten teenagers have actively thought of such. (i.e. A class of thirty students will therefore have approximately 7 students that would have at one time seriously considered or attempted suicide.)

Where any person is deemed as a risk to themselves or to another in this category it is imperative that others are brought into the situation and that the matter is given urgent attention.

Although we respect the autonomy of the individual, their insight and judgement may be impaired due to the depressive episode.

Significant others to inform with immediate effect (Dependant on Base or Operational Location Structure)

- School Leader or Circle Leader
- Training Team Coordinator
- Ministry Leader
- Membercare
- If Stage 2 or 3. Planning and Decision Stage. (See Below.) Base Leader to be informed
    - Advanced planning stage one should strongly consider informing parents or next of kin in a supportive way to the distressed
- Should these roles not be on your base, please ensure that the next significant person of authority be informed

We must hone our skills so that we don’t miss the chance to intervene appropriately and effectively.

Risk Stages and Management thereof.

- **Stage 1. Ideation.**
  During this stage, a depressed person finds him/herself thinking about suicide more and more. However, the fear of suicide still outweighs its attraction. Therefore, the person may be thinking dark thoughts (“my family would be better off without me”), obsessing over dark music (i.e., playing the same depressing song over and over again), or expressing thoughts of death, suicide, pain, and hopelessness through artistic expression, but has not yet begun to formulate a specific plan. People in Stage 1 are low risk, even though some are involuntarily hospitalized for expressing thoughts of suicide in this stage.

  Management
    - Investigate a supportive helping process for the individual should they be wanting help. It is worth noting that sufferers are frequently ambivalent *(having mixed feelings or contradictory ideas about something, someone or process.)* or even resistant to seeing a health professional. This should not discourage the helper;

- Refer to a medical health practitioner for further assessment of depression and possible medical treatment options involving medication and psychotherapy;
- Inquire from medical health professional on any matters of care that may be considered helpful between consultations;
- Close monitoring from school leader or circle leader is needed at this stage as it can escalate to Stage 2.

- **Stage 2. Planning Stage**
  During this stage the person's painful thinking can begin to turn to formulating a specific plan for suicide. Depression worsens at this stage and may be evident to others. E.g. Withdrawal from touching others or from being touched by others, or they may stop verbalizing their pain and suffering while seeming to be in more pain than ever are some evident symptoms of this stage. Isolation from relationships can also be quite common. They are considered medium risk, although they are in critical need of effective psychological and psychiatric care.

  Management.
  - Engage with a therapist for further help;
  - Refer to a medical health practitioner for further assessment of depression and management;
  - Consider accompanying patient to the Dr's appointment with their permission. Confusion is a common symptom at this stage and heightens the risk of information given being misunderstood or not reported;
  - If such a stage is accompanied by other symptoms of mental disturbance such as, hallucinations, delusions, or has been previously diagnosed with a known illness such as Bipolar Disorder or PTSD, inform consulting Doctor and request possible referral to a Psychiatrist, for further management;
  - Vigilance and close observation of the distressed must be strongly considered. Other staff or students may need to be involved to achieve this. Be clear in your communication of what may be required of them. Put into place who they can report any concerns to, hereby helping to mitigate some of the carer's possible anxiety. Someone in this role should be available at all times;
  - Inform the carers of who else is involved in managing the situation. This may help the carers feel less overwhelmed;
  - Regular debriefs for the carer must be arranged with a more extensive debrief once the person or situation is more stable again;
  - Align a caregiver to administer medication if necessary;
  - Reduce access to means of suicide e.g. knives, scissors, poisons, medications;
  - Maintain a daily log of person's behaviour and interactions;
  - Should such a measure of distress felt for the individual prove difficult to be contained, **you might have to consider sending the person home or to a safer environment.** Engage with those who have been part of the helping process as such a move can heighten the suicide risk to the individual. Engage also with those who might be receiving the distressed home. Involve the distressed person in the decision making process in a patient, sensitive and caring manner so as not to create alarm.

Stage 2 rarely lasts longer than several months because it is a very psychologically painful place to be. The person feels compelled to make a decision to commit suicide (thus moving into Stage 3) or not to commit suicide at that time; a decision that most people do not discuss with loved ones and often wrestle with in isolation.

- **Stage 3 Decision to suicide.**
  The moment the decision is made, it goes "unconscious" and the person goes on what we call "auto-pilot." People in Stage 3 are imminently lethal; however, they seem more "normal" than they have seemed in a long time. At this point, the depression seems to suddenly lift because the person has made the decision to die and is no longer wrestling with the decision. Unfortunately, most mental health professionals and family members are not trained to recognize "auto-pilot," and they breathe a sigh of relief because their patient seems so much better, not realizing that he/she is on a collision course with suicide. People on "auto-pilot" typically attempt suicide within the next 48 hours. Be alert when a depressed patient who doesn't seem to improve after months of intervention suddenly seems to get better. Instead of relaxing, we should become more vigilant when we see a sudden, overnight improvement. We should listen closely to any indication that the individual has decided to end their life and mobilize support among family, friends, medical and psychological health providers.

  Management
  Besides implementation of objectives for Stage 2, the following additional measures should be implemented.
  - 24-hour constant watch must be implemented with immediate effect until time of hospitalization
  - Request Hospital admission into high care. (We do not have the resources to manage this stage)

- Presentation of the log book of person's history of behaviour and interactions may help to assist in this case
- Involve next-of-kin as far as possible with information released from hospital

Factors for consideration

When people are profoundly depressed and suicidal, the usual treatment includes antidepressant medications. The risk for suicide may increase instead of decrease in the early stages of antidepressant treatment. The so-called "vegetative" signs of depression, such as very low energy and the inability to think clearly, improve before the "cognitive" symptoms. These depressed people have enough mental clarity and energy to follow through with a suicide, while they still feel profoundly depressed and hopeless.

Management.

Close observation needs to be maintained in earlier stages of treatment for at least the first six weeks or until a medical health professional is confident that the depression is under control and in remission.

As mental health professionals have assisted in the drafting and evaluation of this document, amendments thereto should not be effected without such a professionals' consent.

Document 2.
SUICIDAL INQUIRY
ASSESSING SOMEONE WHO MAY BE AT RISK OF SUICIDE.

This document is set out to assist the lay person. It would be important that one acknowledges that one may not be a professional in this case. NB: Please refer to footnote at the end of the document.

The Interview Setting
Assessment should take place in a quiet room where the chances of being disturbed are minimised. Ideally you should meet with the patient alone but also see their family/carers/ friends, together or alone, as appropriate. In general, open questioning is advisable although it may become necessary to use more closed questions as the consultation progresses and for purposes of clarification.

There is no definitive way to approach enquiring about suicide, but it is essential that this is assessed in anyone who has expressed suicidal thoughts or are depressed.

There may be circumstances under which assessment is conducted by telephone. This will clearly place limitations on the assessment procedure (e.g. access to non-verbal communication). However, the principles of assessment are the same. Where feasible, a face-to-face assessment is recommended.

Non-Verbal and Verbal Clues
It is important to pay heed to non-verbal clues and intuitive feelings about a person's level of risk.

- Non-Verbal clues may include.
    - Downcast eyes or poor eye contact
    - Less attention to appearance
    - Psychomotor – the effects of the brain on retardation, slowness of speech and or of movement

- Verbal Clues may include comments like.
    - Everyone would be better off without me
    - I don't think I can take this much longer
    - Expressing feelings of hopelessness

Risk Factors
Sometimes a person with few risk factors may nevertheless make an interviewer feel uneasy about their safety. The interviewer should not ignore these feelings when assessing risk, even though they may not be quantifiable. Seek help from a further qualified person when in doubt.

Suicidal behaviour is associated with many different types of events, illnesses, and life circumstances. The strongest predictor of suicide is one or more previous attempts; however, most people who die by suicide die on their first attempt.

There are many factors that increase risk for suicide. A greater number of identified risk factors suggests a greater risk.

Individual Risk Factors
- Previous suicide attempt;
- Major physical illnesses, especially with chronic pain;
- Central nervous system disorders, including TBI (Traumatic Brain Injury);
- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders (e.g., *PTSD), and certain alcohol and other substance use disorders; personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD). In youths: ADHD and conduct disorders (antisocial behaviour, aggression, impulsivity);
- Repetition of deliberate self-harm (DSH) is a risk factor for suicide;
- Psychiatric symptoms/states of mind: anhedonia, severe anxiety/panic, insomnia, command hallucinations, intoxication, self-hate;
- Impulsive and/or aggressive tendencies;
- History of trauma or abuse;
- Family history of suicide;
- Precipitants/triggering events leading to humiliation, shame, or despair (e.g., loss of relationship, health or financial status – real or anticipated);
- Successful suicide of family member, loved one, friend etc.
- Life changing events.

Social/Environmental Risk Factors

- Chaotic family history (e.g., separation or divorce, change in caretaker, change in living situation or residence, incarcerations);
- Lack of social support and increasing isolation;
- Easy access to/familiarity with lethal means (e.g., guns, illicit drugs, medications);
- Local clusters of suicide that have a contagious influence;
- Legal difficulties/contact with law enforcement/incarceration;
- Barriers to accessing health care, especially mental health and substance abuse treatment;
- Life changing events.

Societal Risk Factors

- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma);
- Exposure to, including through the media, and influence of others who have died by suicide.

Starting an inquiry process.

One will generally not spontaneously report suicidal ideation, but 70% communicate their intentions or wish to die to significant others. Ask directly about suicide and seek collateral information from others such as family members, friends, other caregivers, colleagues etc.

Some patients though will introduce the topic without prompting, while others may be too embarrassed or ashamed to admit they may have been having thoughts of suicide. Careful and sensitive questioning is essential. **Use non-judgemental, non-condescending, matter-of-fact approach.**

It should be possible to broach suicidal thoughts in the context of other questions about mood symptoms or link this into exploration of negative thoughts.

- **Example**.
    - It must be difficult to feel that way – is there ever a time when it feels so difficult that you've thought about death or even that you might be better off dead?
    - Sometimes, people in your situation (describe the situation) lose hope; I am wondering if you may have lost hope, too?
    - Have you ever thought things would be better if you dead?
    - With this much stress (or hopelessness) in your life have you thought about hurting yourself?
    - Have you ever thought about killing yourself?

Another approach is to reflect back to the patient your observations of their non-verbal communication.

- **Example.**
    - "You seem very down to me". "Sometimes when people are very low in mood they have thoughts that life is not worth living: have you been troubled by thoughts like this?").

Depending on the answers to these questions above one may have to evaluate the risk further. You may want to ask about a number of topics, starting with more general questions and gradually focusing on more direct ones, depending on the patient's answers. This must be done with respect, sympathy and sensitivity. It may be possible to raise the topic when the patient talks about negative feelings or depressive symptoms. It is important not to overreact even if there is reason for concern. Areas that you may want to explore include the following:

- Are they feeling hopeless, or that life is not worth living?
- Have they made plans to end their life?
- Have they told anyone about it?
- Have they carried out any acts in anticipation of death (e.g. putting their affairs in order)?
- Do they have the means for a suicidal act (do they have access to pills, insecticide, firearms...)?
- Is there any available support (family, friends, carers...)?

Sample questions and process to facilitate conversation to further assess risk.

The following questions or similar to could be asked in the order given until the line of question may no longer be necessary.

Risk level is likely to increase for suicide with the more positive and detailed responses to these questions.

Stage One: Ideation. Assessment.

- Passive Suicidal Thoughts.

- Do you wish you didn't have to go on living?
- Do you have thoughts of wanting to die?
- When did these thoughts begin?
- Did any event (stressor) precipitate the suicidal thoughts?
- How frequent do these thoughts happen?
- Are they fleeting or do they remain for any length of time?
- What is the worst they have ever been?
- What do you do when you have suicidal thoughts?
- What did you do when they were the strongest ever?

- Active Suicidal Thoughts
  - Do you have thoughts of wanting to take your own life?
  - How strong are they?

- Suicidal Threats
  - Have you spoken about killing yourself with others?
  - Have you told anyone that you were going to kill yourself?

Stage Two: Plans

- Suicide Plans
  - Do you have a plan or have you been planning to end your life?

- Suicide Plans. – the details
  - Have you been thinking of any particular method?
  - If so how far have you gone in that thought? (E.g. Research)
  - Have you decided on a method?
  - Did you make a plan of exactly how you might carry such a thought out?
  - Is there something or an event that would trigger the plan?
  - Do you have the means to do it?
  - Where would you do it?

- Resistance
  - Have you been able to resist carrying this out?
  - What stopped you putting the plan into action?

- Preparations
  - Have you started preparations to suicide?

- Time Profile
  - For how long have you had the plan?
  - Do you have a timeline in mind for ending your life?

- Affairs
  - Have you put your affairs in order?
  - Have you made arrangements for after you die?
  - Have you written a note?

- Visual Imagery (There is increasing evidence that visual imagery can strongly influence behaviour)
  - Do you have any images about suicide (e.g. "If you think about suicide, do you have a particular mental picture of what this might involve?").
  - Access to means
    Does the person have access to means to carry out their plan?
    How deadly is the method of the plan devised?
    Type of occupation? Health worker access to drugs, farmer access to guns or other farm equipment, chef access to knives.

Important Note. If a person has developed a potentially fatal or effective plan and has the means and knowledge to carry it out, the chances of dying from suicide are much higher.

Stage Three: Decision.

Any kind of indifference, vagueness or diverting of the questions should be inquired upon further with intent. **Such behaviour could indicate of a decision already made.** It is possible that they would not want to engage as it may cause them to think that it will only take them back to the place of pain, anguish or distress felt before they

made the decision. They may also not want the relief felt after such a decision to be questioned or interfered with. People suffering with this depth of depression or distress often believe that help is not possible, or that it will not help or that they may not be worth the time of another person's efforts.

- Intent
  Determine the extent to which the distressed person expects to carry out the plan and believes the plan or act to be lethal vs. self-injurious.
  - What would it accomplish if you wanted to end your life?
  - Do you feel as if you a burden to others?
  - How confident are you that this plan would actually end your life?
  - What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do? (e.g. updated life insurance, made arrangements for pet's etc.)
  - What makes you feel better? (e.g., contact with family, use of substance.)
  - What makes you feel worse? (e.g., being alone, thinking about the situation.)
  - How likely do you think you are to carry out the plan?
  - What stops you from killing yourself?

Look for disagreement between what you see (objective findings) and what the distressed person tells you about their suicidal state (subjective findings). When possible, and always with adolescents, seek to confirm with a family member, spouse or close friend. A distressed person is at time more likely to tell a family member than a Primary Care Physician that they are suicidal. It can also be helpful to explore the distressed cultural and/or religious beliefs about suicide and death.

Prior Attempts
A history of a prior attempt is the strongest predictor of future suicidal behaviour. Always ask if the distressed has attempted suicide in the past, even if there is no evidence of recent suicidal thinking.
In this assessment observe if there may be similarities to the current situation compared to previous attempt or attempts.

Previous Suicide Attempt/s

- Circumstances
  - What were the circumstances of this attempt?

- Method
  - What did you do?

- Intent
  - What did you want to achieve (to die/to sleep/euphoria)?
  - Lethality
  - Did you think it would kill you?

- Reattempting Suicide
  - Have you ever tried to take your own life before this attempt?

- Willingness for help
  - Desire for help
  - Do you want help to avoid trying this again?

- Acceptance of care
  - Will you accept my help to avoid suiciding?
  - Will you accept specialist mental health care?

Someone perceived to be in imminent danger of suicide

Assess the current level of safety with some of the following possible questions.

- Immediate Harm
  - Do you have thoughts of wanting to commit suicide immediately?
  - Do you have thoughts of wanting to commit suicide or self-harm here in the office/house, etc?
  - Are you thinking of actively wanting to hurt yourself here?

- Help Eliciting.

- If you feel like hurting yourself here while you are waiting for me to make some arrangements could you come back to me and indicate this before doing anything?

- Dangerous Items.
  - Do you have anything you can use to harm yourself?
  - Are you thinking of using something in the immediate vicinity to harm yourself with?
  - If so what might that be?

- Homicidal Thoughts.
  Homicidal Ideation
  - Do you want to take anyone with you?
  - Do you have thoughts of harming or killing others?

- Homicidal Plan.
  - Do you have a plan to do this?

- Weapons
  - Do you have access to any weapons such as knives or other weapons?

Protective factors for suicide.
In addition to an assessment of the risk, a comprehensive approach to management of suicide focuses on the identification and fostering of protective factors, which can reduce the risk of suicide. Protective factors to consider when creating a management plan include:

- Personal
  - Adaptive coping skills
  - Effective problem-solving skills
  - Self-understanding
  - Sense of competence
  - Spirituality
  - Strong therapeutic relationship

- Work
  - Supportive work environment
  - Positive relationships with colleagues
  - Professional development opportunities
  - Access to employee assistance programs

- Family
  - Relationship to family
  - Sense of responsibility

- Community
  - Involvement and opportunities to participate
  - Affordable, accessible supportive services

Abbreviations.
*PTSD. Post-Traumatic Stress Disorder.

This document “Document 2” is intended to present guidelines to assess risk. “Document 1” is intended to create awareness of suicidal thinking, and to set out best practice for management. They are independent documents yet they are together. The one cannot exist without the other. While care has been taken in the drafting of this document, the author cannot be held liable in any manner whatsoever for the use or misuse of this guide.

These questions are an educational reference for a caregiver to perform a measured risk assessment in regards to suicidality. They may assist the interviewer in further assessment of risk for the individual concerned. This is not a replacement for an individual clinician’s judgement, responsibility and duty of care towards the distressed. The author takes no responsibility for the use of this guide.

As this has been evaluated and helped to be compiled by mental health professional’s amendments to such should not be done without such a professional’s consent.

David Peter
Africa Membercare Co-ordinator.

POST-TRAUMATIC STRESS DISORDER (PTSD)

THE "INVISIBLE INJURY"

PTSD is where the traumatic event can be persistently re-experienced in one or more of the following ways: It can have its onset as long after as three to six months after the event. It has also been showing that a Critical Incident Debrief after or during a crisis can assist in minimizing or preventing the onset of this.

In the event of one experiencing symptoms of PTSD it is strongly advisable that further therapeutic and counselling care be provided for the individual. If such is not available at the very least provide for a safe and non-judgmental and regular place where the sufferer can talk through the feeling and thoughts experienced.

Symptoms Experienced but also not limited to.

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions;
- Recurrent distressing dreams of the event;
- Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated);
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event;
- Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

The individual also has persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by 3 or more of the following:

- Efforts to avoid thoughts, feelings, or conversations associated with the trauma;
- Efforts to avoid activities, places, or people that arouse recollections of the trauma;
- Inability to recall an important aspect of the trauma;
- Significantly diminished interest or participation in significant activities;
- Feeling of detachment or estrangement from others;
- Restricted range of affect (e.g. unable to have loving feelings);
- Sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span).

Persistent symptoms of increased arousal (not present before the trauma), as indicated by 2 or more of the following:

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response.
- The disturbance, which has lasted for at least a month, causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

If PTSD symptoms persist:

a. Arrange for thorough physical examination;
b. Provide proper sympathetic professional counselling;
c. Do not allow a return to normal work for serious sufferers of PTSD for approximately six months.

COMMUNICATION AND MEDIA GUIDELINES

When Media Gets Involved

After the first response in a crisis, a communications team needs to get to work to prepare for any eventuality. The following are some guidelines, keeping in mind that often events will move quickly and you will not always get to do everything the way you want to.

1) Discover the facts

- Gather the facts of the critical incident;
- If in the event that a situation may become critical, try and gather the facts before the incident.

2) Confirm the authority structure

- Who is authorized to make decisions? Local or Area Circle Leader should always be involved; especially in cross-cultural situations. In consultation with Area Leadership, Global Leadership should be informed in a major crisis, but those involved locally must be involved in deciding how their story is told;
- And remember: check to make sure you are not holding on to or sharing information for the wrong reasons. Information is power, and it is important not to let that power dictate your response.

3) Know your message

- Be clear and know what message you want to communicate. Even though the media can twist things be sure you are very clear about what you want to say.

4) In developing your message think of the world as your audience

- You are not just communicating to the church or to an evangelical audience anymore. Are you sure that what you are communicating is understandable? (This doesn't mean everyone agrees with what you are saying but they understand what you are communicating). Don't use spiritual jargon or YWAM-ese. Think about how your message will sound to secular or other-faith persons as well as how it will be felt by the people you are speaking about. Be careful about just involving the word YWAM especially if such an event could have a larger impact regionally or globally.

5) Whenever possible (i.e. not in a secure situation) it is good to work with the media

- Not everyone in the media is against us and even if they are we can use them to communicate our core message. But always be led by the people involved in this – particularly when the situation involves nations without freedom of religion.

6) When answering questions from the media remember

- Do not assume that you can speak on behalf of Youth With A Mission, and recognize that it will sometimes be assumed that you are. Clarify who you do represent;
- You don't have to answer all questions, but "no comment" is rarely a helpful statement. Explain *why* you can't comment: I don't have that information, I need to check that information with someone else, we are not involved with that situation, we are not able to discuss that for legal reasons, etc.
- If you are asked about a situation you are not aware of, or which doesn't involve you, you should say, "I'm sorry, I don't have that information. We are a highly decentralized organization. If you could email me some questions I would be happy to get back to you later today. "Or, "Someone else would be better to answer that question. If you give me your contact details, I'll have them call you back.";
- Always ask questions first – who are you? What newspaper to do you represent? What exactly do you mean?

Drafting A Press Statement

Press statements should be prepared as much in advance of publication as possible. In a crisis, preparation of a statement, anticipating various outcomes, should be a matter of priority. A spokesperson to deliver the statement should be appointed and all staff who may have contact with the press (i.e. whoever answers the phone, students, national office, etc.) should be informed of where to direct inquiries.

If you are not authorized to speak in a situation, don't be provoked! Simply reply politely that a spokesperson has been appointed for the situation to ensure that the correct information is given. In some situations, this will also be to respect the privacy of people involved.

Some general guidelines for the spokesperson:

- be entirely accurate and make sure your facts are correct
- be clear and concise as possible
- write in the third person unless you are speaking on behalf of yourself
- avoid jargon unless you define it clearly
- determine your key message and stick to it
- communicate in multiple languages where appropriate
- clearly indicate a source/spokesperson for follow up if you want it and make sure the source has anticipated questions and is prepared to deal with media
- check the spelling and grammar before you release it

For drafting content for a press statement:

1) Briefly identify who you are speaking on behalf of

- If you are speaking on behalf of YWAM, define which part of YWAM. You may not speak above the position you have without authorization. In other words, you cannot speak on behalf of YWAM Global unless you have the authority. Clarify if you are speaking for a nation, region, or particular centre or just on behalf of a certain individual or group. General statements about YWAM to help identify who we are and what we do can be taken from ywam.org, or seek assistance from the press office;
- In situations where you are speaking on behalf of an affiliate which is not directly associated with YWAM (i.e. an NGO), make clear who the organization is and where they are located, and, where appropriate, how they are legitimized (i.e. "affiliated with the Evangelical Alliance/working with the UN/overseen by <relevant government body>). Do not speak on behalf of another organization unless you are authorized to do so.

2) Make your statement, concisely addressing the issue and keeping to your message. Answer the questions: what has happened? What led up to this event? What is your response/what do you expect will happen next?

- Stick to the point – don't digress – but make sure your statement has context;
- Make your statement credible – give evidence to support your statement where appropriate, but keep it concise. This could include statements about your service record in the area, your good relationships with other credible groups, personal testimonies, etc.;
- Do not reference other YWAM or other ministries without their permission;
- Keep it clear and simple to avoid misinterpretation.

3) Decide if you will answer questions, anticipate the questions and be prepared to answer them. Some useful responses to common questions…

- "That's a very important question, but even more important is…";
- "Before I answer that question, I think I should say…";
- "I don't have the exact details, but what I can say is…";
- Don't be afraid to contradict or correct;
- "You might say that, but in my experience…";
- "No, that is not true. The truth is…";
- Try not to say "no comment." If you don't have/can't give information, say so, and explain why.

A PROPOSED DEBRIEFING MODEL

Debriefing from a Trauma Situation:
Debriefing a trauma is of vital importance. Everyone experiences and interprets a traumatic event differently. We need to understand that and embrace it. We should understand that everybody experiences a trauma differently.

Profile of the Debriefer.

- A good understanding of the active and reflective listening skills and has practiced this at times.
- Must feel safe with the individual.
  Naturally affirm an individual's perceptions, and feelings.
  Some form of training in counselling to know what clues to listen to.
  The ability to share their own story.
  Ability to display warmth, empathy and respect appropriately.

A Plan for Debriefing
The following outline has been built upon the CISM model: (Critical Incident Stress Management)

Debriefing for maximum effect should be made up of two stages.

Stage 1
Group process (30-45 min.) provided immediately after a traumatic event. This happens once the individuals are away from the location of the traumatic event.

Goals and Process of Debriefing After a Traumatic Event:

- mitigate or lessen the impact of the event
- accelerate the recovery process
- assess the need for debriefing or other support
- reduce cognitive, emotional, and physiological symptoms

The process of the debriefing aims to:

- establish a non-threatening social environment
- allow for immediate vocalising of stressful experience
- share facts and information to all concerned
- bringing understanding, which increases the ability to reason in the midst of trauma
- provide information for coping in the midst of stress
- affirm the value of individuals
- communicating what can be expected in the process going forward

The debriefing components are as follows:

1. Introduction
   - introduce facilitator (hosting - creating an emotionally safe atmosphere)
   - state the purpose for the debriefing
   - invite voluntary participation
   - establish ground rules (not necessarily therapy, not investigation)
   - assure confidentiality (no notes, recordings, etc.)
   - describe the process
   - offer additional support (e.g. follow up debriefing)

2. Exploration
   - ask individuals to describe what just occurred (open-ended questioning)
   - allow only minimal clarification questions (silence, paraphrasing)
   - review experiences and reactions (summarizing skills)
   - assess need for further help
   - reassure when necessary

3. Information
    - reflect back what you have heard in order to show understanding of their journey
    - normalize experiences and reactions (extend empathy and support; speak from personal experience if possible)
    - teach multiple stress survival skills (elicit experiences from individuals)
    - advise on diet & nutrition, alcohol/caffeine avoidance
    - pay attention to proper rest & maintain significant relationships
    - recommend recreation & exercise (speak from experience)

4. Aftermath
    - follow up with those that may need more individualised care
    - assure one-on-one follow-up where possible
    - suggest follow up debriefing, if required, and what that might look like

The debriefing process may provide sufficient support to groups or individuals, however it may happen that the debriefing will reveal the need for further support.

Indicators that additional support may be necessary include:

- intense emotions, unusual behaviour
- unfinished business
- a sense (sometimes subtle) of incompleteness
- excessive silence

Stage 2.

A follow up meeting of duration of 2 to 3 hrs approximately 72 hrs after the event should aim to serve the following points.

- limiting ongoing stress in a situation
- screen and prioritize individual needs
- identify areas for follow-up support and referrals

The following outline is a good example to follow, it is made up of seven steps.

Stage 1	Introduction	Introduce intervention team members, explain process, set expectations, establish confidentiality (active listening throughout process)
Stage 2	Fact	Have each participant describe the nature of their participation, from a cognitive perspective. “What did you see/hear/do?” (open-ended, fact focused questions)
Stage 3	Thought Reaction	Solicit cognitive responses to: “What were you thinking as this was happening? What aspect held the most negative impact for you?”, transition from cognitive to emotional processing. (open-ended, cognitive focused questions)
Stage 4	Emotional Reaction	Solicit emotional reactions to or consequences of cognitive responses given in Stage 3. “How has this experience affected you?” (open-ended, emotional focused questions)
Stage 5	Reframing	Transition from emotional domain back to cognitive. “What lessons could be learned from this experience?” or “What is something positive that you will take away from this experience?” Be gentle here - Do not insist that people identify positive learning if they are not ready. (open-ended, reframing questions)
Stage 6	Teaching	Educate participants to normal reactions (not necessarily shared by everyone) and teach basic stress management, if applicable. (disclosure, speaking skills)
Stage 7	Re-entry	Summarize experience with emphasis on positive learning aspects.

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1. **Good practice for helping traumatized people – Latest Research**
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Dave Peter
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